South Dakota Board of Nursing
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: (605) 362-2768 ♦ www.nursing.sd.gov

Advanced Practice Nurse Licensure Renewal

To renew your license(s) all forms and fees must be postmarked by your expiration date or your license(s) will lapse. **You cannot work on a lapsed license(s)**, and you are responsible to maintain licensure whether or not you receive a renewal notice.

Please follow instructions carefully to avoid delays in processing your renewal. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees at the South Dakota Board of Nursing office your application will be considered for renewal. You will be notified in writing if additional information is required.

To renew your CNM, CNP, CRNA, or CNS (APN) license you must also be actively licensed as a Registered Nurse. SD is a compact RN state; for more information on compact states, see www.ncsbn.org.

- If South Dakota is your primary state of residence, or if you reside in a non-compact state, you must renew your SD RN license to meet this requirement.
- If you reside in a Compact State, and your RN license in that state is active, provide a copy of your active multi-state compact RN license to be verified by the South Dakota Board of Nursing.

To renew your nursing license(s) ***submit the following*** to the South Dakota Board of Nursing office at the address listed above:

- Completed Application for Advanced Practice Nurse Renewal Form
- Completed Verification of Employment Form
- Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A $20 fee will be charged for any insufficient check written.

Fees required to renew both South Dakota RN license and APN license: $90 RN renewal fee + $70 APN renewal fee = **$160**
Fee required to renew South Dakota APN license only (hold valid compact RN license with multi-state privileges): $70 APN renewal fee = **$70**

To ***Inactivate*** your nursing license(s) complete and submit to the South Dakota Board of Nursing office:

- ☐ Inactivation request
- ☐ Fee payment

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Application for Advanced Practice Nurse Renewal

I request to RENEW each South Dakota license checked:

☐ *RN: License #(s): _____ ☐ CRNA: License #(s): _____
☐ CNM: License #(s): _____ ☐ CNS: License #(s): _____
☐ CNP: License #(s): _____

*To practice as an APN in SD, you must hold both an RN license and an APN license. SD is a compact RN state; for more information on compact states, see www.ncsbn.org.

(Please Print)
Name: First_____ Middle_____ Last _____

Other names previously used:_____ _____
Date of Birth

Address:_____
Street/PO Box City State Zip

Telephone: Home: (___)_____ Other: (___)_____ Email: _____

Declaration of Primary State of Residence

I declare _____ to be my primary state of residence. Primary state of residence is where you hold a driver's license, pay taxes and/or vote. This state is referred to as my "home state" under the Nurse Licensure Compact and means that it is my "declared fixed permanent and principal home for legal purposes".

The following can be used to document residency pursuant to the Compact laws and rules.

1. Driver's license with a home address.
2. Voter registration card displaying a home address.
3. Federal income tax return declaring the primary state of residence.
4. Military Form No. 2058 – state of legal residence certificate.
5. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.

Military/Federal Employees

A federal government/military nurse practicing exclusively in federal or military systems, need only have one license from any state or territory per U.S. federal government/military policy. A federal or military nurse who also practices in a civilian health systems is bound by the Compact law and rules.

A federal/military nurse who has proof of residency in a Compact party state may be issued a Compact license with a multi-state practice privilege. A federal/military nurse who does not have proof of residency in a Compact party state may be issued a single-state license regardless of where the nurse is residing. A military/federal nurse may not hold a multi-state license from more than one Compact state at a time.

Are you employed by the military or practicing in a Federal institution?

☐ **Yes**
☐ **No**

Collaborative Agreement Information (Applicable to CNM and CNP ONLY)

To perform the overlapping scope of advanced practice nursing and medical functions with a physician licensed in South Dakota as defined in SDCL 36-9A-12 and SDCL 36-9A-13, CNMs and CNPs must have on file a current Joint Board of Nursing and Medical and Osteopathic Examiners approved collaborative agreement (SDCL 36-9A-15 and SDCL 36-9A-17).

Collaborative Agreement renewal is not required with licensure renewal, as long as the terms defined in the agreement describe current practice. The CNP/CNM is accountable to maintain current status of all collaborative agreements on file with the Boards. Once a collaborative agreement has been reviewed and approved by the Boards, it remains in effect until a new collaborative agreement has been submitted and approved. To obtain a collaborative agreement, go to the Board of Nursing website at www.nursing.sd.gov, select Site Index then Collaborative Agreement.

- ❑ I do not have a collaborative agreement on file with the Boards. I do not perform the overlapping scope of advanced practice nursing and medical functions as defined in 36-9A-12 / 36-9A-13.
- ❑ I have included a new or revised collaborative agreement with this application to be approved by the Boards.
- ❑ I have an approved collaborative agreement(s) on file with the Boards. My **primary physician(s)** are listed below:

Primary Physician: _____

Primary Physician: _____

Certification Information

Primary source verification of *current* certification from a Board-approved certification organization specific to your area of practice is *required* to be on file with the Board office prior to your APN license being renewed. If you are unsure if you have current certification on file, contact the Board office. Photocopies of certification documents are not accepted.

- ❑ Primary source verification showing evidence of my current certification is already on file with the BON office. If so, you do not need to resubmit.
- ❑ I am a CRNA, AANA# _____. Primary source verification of your re-certification status will be monitored on NBCRNA's verification website.
- ❑ I do not have primary source verification of my certification on file with the BON, I have sent the Certification Verification Form to my certifying organization to be sent to the SD BON verifying my on-going currency of certification.
  - ○ CNPs or CNSs certified with NCC or ANCC must submit on-line requests to NCC and ANCC for primary source verification to be sent to the BON.
- ❑ I am exempt from the certification requirement. I was originally licensed as a CNP/CNM in South Dakota before June 26, 1996 or as a CNS before July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.

Disciplinary Information

If "YES" is answered to any of the below questions please attach a detailed explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion / compliance with court requirements.

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations?	❑ Yes	❑ No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❑ Yes	❑ No
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❑ Yes	❑ No
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❑ Yes	❑ No
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❑ Yes	❑ No
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❑ Yes	❑ No
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	❑ Yes	❑ No
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❑ Yes	❑ No
9.	Do you currently owe child support arrearages in the amount of $1000 or more?	❑ Yes	❑ No

Employment and Education Information:

What type of nursing degree / credential qualified you for your first U.S. nursing license?

- ☐ Vocational / Practical Certificate Nursing
- ☐ Diploma – Nursing
- ☐ Associate Degree – Nursing
- ☐ Baccalaureate Degree – Nursing
- ☐ Master's Degree – Nursing
- ☐ Doctoral Degree – Nursing

What is your highest level of education?

- ☐ Vocational / Practical Certificate Nursing
- ☐ Diploma – Nursing
- ☐ Associate Degree – Nursing
- ☐ Associate Degree – Non-Nursing
- ☐ Baccalaureate Degree – Nursing
- ☐ Baccalaureate Degree – Non-Nursing
- ☐ Master's Degree – Nursing
- ☐ Master's Degree – Non-Nursing
- ☐ Doctoral Degree – Nursing (PhD)
- ☐ Doctoral Degree – Nursing Practice (DNP)
- ☐ Doctoral Degree – Nursing Other
- ☐ Doctoral Degree – Non-Nursing

Year of initial U.S. Licensure: _____

Country of entry-level education: _____

What is your employment status?

Actively employed in nursing or in a position that requires a nurse license (select one)

- ☐ Full-time
- ☐ Part-time
- ☐ Per diem

Actively employed in a field other than nursing (select one)

- ☐ Full-time
- ☐ Part-time
- ☐ Per diem

Working in nursing only as a volunteer

- ☐

Unemployed (select one)

- ☐ Seeking work as a nurse
- ☐ Not seeking work as a nurse

Retired

- ☐

In how many positions are you currently employed as a nurse?

- ☐ 1
- ☐ 2
- ☐ 3 or more

How many hours do you work during a typical week in all your nursing positions?

- ☐ <10 hours
- ☐ 11-20 hours
- ☐ 21-30 hours
- ☐ 31-40 hours
- ☐ 41-50 hours
- ☐ 51-60 hours
- ☐ >60 hours

Indicate the zip code, city, state and county of your primary employer.

Zip Code: _____

City: _____

State: _____

County: _____

Identify the type of setting that most closely corresponds to your nursing practice position.

- ☐ Academic Setting
- ☐ Ambulatory Care Setting
- ☐ Community Health
- ☐ Correctional Facility
- ☐ Home Health
- ☐ Hospital
- ☐ Insurance Claims / Benefits
- ☐ Nursing Home / Extended Care / Assisted Living Facility
- ☐ Occupational Health
- ☐ Policy / Planning Regulatory / Licensing Agency
- ☐ Public Health
- ☐ School Health Services
- ☐ Other

Identify the position title that most closely corresponds to your nursing practice position.

- ☐ Advanced Practice Nurse
- ☐ Consultant
- ☐ Nurse Executive
- ☐ Nurse Faculty
- ☐ Nurse Manager
- ☐ Nurse Researcher
- ☐ Staff Nurse
- ☐ Other – Health Related
- ☐ Other – Non Health Related

Identify the employment specialty that most closely corresponds to your nursing practice position.

- ☐ Acute Care/ Critical Care
- ☐ Adult Health / Family Health
- ☐ Anesthesia
- ☐ Community
- ☐ Geriatric / Gerontology
- ☐ Home Health
- ☐ Maternal-Child Health
- ☐ Medical / Surgical
- ☐ Occupational Health
- ☐ Oncology
- ☐ Palliative Care
- ☐ Pediatrics / Neonatal
- ☐ Psychiatric / Mental Health / Substance Abuse
- ☐ Public Health
- ☐ Rehabilitation
- ☐ School Health
- ☐ Trauma
- ☐ Women's Health
- ☐ Other

What percent of your current position involves direct patient care?

- ☐ 0%
- ☐ 25%
- ☐ 50%
- ☐ 75%
- ☐ 100%

If unemployed, please indicate the reasons.

- ☐ Difficulty in finding a nursing position
- ☐ Disabled
- ☐ Inadequate Salary
- ☐ School
- ☐ Taking care of home and family
- ☐ Other

Formal Education

- ☐ I am not taking courses toward an advanced degree in nursing
- ☐ I am currently taking courses toward an advanced degree in nursing

Do you intend to leave / retire from nursing practice in the next 5 years?

- ☐ Yes
- ☐ No

Other states in which you have ever held a license:

Active License: _____

Inactive License: _____

List all states where **currently practicing** nursing, whether physically or electronically:

_____

Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____

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Inactive Status: Should you wish to place your nursing license on inactive status, submit completed written request below along with fee to the South Dakota Board of Nursing office before your nursing license expires.

I request to INACTIVATE each license checked:

- ☐ SD RN License Number: _____
- ☐ SD CNM License Number: _____
- ☐ SD CNP Licensure Number:_____
- ☐ SD CRNA Licensure Number: _____
- ☐ SD CNS License Number: _____

Name (First): _____ (Middle): _____ (Last): _____

Address:_____
Street/PO Box City State Zip

Telephone: Home: (___)_____ Other: (___)_____ Email: _____

Fee required to inactivate **each** South Dakota license requested is **$10.**

You are required to pay this fee once upon initial inactivation.

Payment should be in the form of a personal check or money order payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A $20 fee will be charged for any insufficient check written.

Sign, date and return this form with fee.

Signature of Applicant _____ Date _____

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VERIFICATION OF EMPLOYMENT

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. **Return completed form(s) via fax, email or mail to the South Dakota Board of Nursing.**

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

Please Print

Name (First): _____(Middle): _____(Last): _____

❒ I have been employed / volunteered as a nurse (LPN, RN, CRNA, CNM, CNP or CNS).

❒ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____ _____
Signature of Applicant Date

This Section to be Completed by Employer
(Provide Employment Hours Within the Last 6 Years)
Note: This section Cannot be Signed by the Applicant

The above-named individual is/was employed/volunteered as a nurse

From _____
Month/Date/Year
To _____
Month/Date/Year

Total hours worked in this period:_____

I the undersigned declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

_____ _____
Signature of Agency Representative/Title Date
Who can verify/confirm number of hours employed/volunteered

Name of Employer: _____

Address of Employer: _____

Telephone: _____ Email: _____

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CERTIFICATION VERIFICATION FORM

Complete items 1 – 8 on this form then forward to certification organization.

Please Print

1. Name, First_____Middle_____Last _____
2. Other names previously used:_____
3. Address:_____City_____State_____Zip_____
   Street/PO Box
4. Name of Certification Organization_____
5. Certification #_____ Expiration Date_____
6. Certification status (check one): ··Initial certification verification ··Recertification verification
7. Certification type (check one): ··CRNA··CNS ··CNM ··CNP
8. Consent to *Release Information* to the South Dakota Board of Nursing:

   I authorize the above named certification organization to disclose information regarding the identification, evaluation, and certification of the above named applicant that is maintained by the above named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

_____ _____
Applicant Signature Date

Certification Organization: complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____

Certification #	**Date of Current Certification Maintenance Cycle/Recertified through:**
Certification type: ··CNM ··CRNA·····CNS– specialty area_____ ··CNP– specialty area_____	
Is certification current? ····YES ·NO (Please explain on a separate paper)	Has certification lapsed? ····YES (Please explain on a separate paper) ·NO
Has certification been revoked? ·YES (Please explain on a separate paper) ·NO	Is certification provisional/conditional in any manner? ·YES (Please explain on a separate paper) ·NO

_____/_____ _____
Name/Signature of person completing form Title Date

6/06